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Section 1317 of California’s Health and Safety Code (“section 1317”) requires emergency departments to provide patients in danger of loss of life or serious illness or injury with emergency care services regardless of the patient’s ability to pay. After providing emergency services, the medical provider, such as the hospital or doctor, may bill the patient or the patient’s insurance carrier. In certain circumstances, however, insurers decline to pay the entire cost of treatment and the medical providers bill the remaining amount to the member/patient. This practice is termed “balance billing.”

In Prospect Med. Group, Inc., v. Northridge Emergency Med. Group, the Supreme Court of California considered whether a physician group could partake in balance billing after providing emergency room care to patients whose insurer did not have a contract with

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2 See CAL. HEALTH & SAFETY CODE § 1317(d) (West 2008) (requiring patient or legally responsible relative or guardian to arrange payment to medical providers following emergency care services); CAL. HEALTH & SAFETY CODE § 1371.4 (b)-(c) (West 2008) (necessitating insurers to reimburse medical providers following emergency services in all but a few specific circumstances).


4 Id. See also infra note 14 and accompanying text (explaining balance billing).

5 198 P.3d 86 (Cal. 2009).
the particular physicians. The court held that under the Knox-Keene Health Care Service Plan Act of 1975 ("Knox-Keene Act") patients could not be billed for the remaining costs.

The plaintiff-appellants, Prospect Medical Group Inc., Prospect Health Source Medical Group and Primary Medical Group, Inc., (collectively "Prospect") are Independent Practice Associations ("IPA"). Prospect manages patient care by executing written contracts with health care service plans ("service plans") also known as Health Maintenance Organizations ("HMOs"), provides medical care for those who select a Prospect physician, contracts with other medical professionals to provide care and offers billing services to those service plans that have contracts with Prospect. As a delegate, Prospect must pay for emergency care provided to patients/subscribers of the service plans regardless of whether Prospect has contracted with the medical providers. The defendant-respondents, Northridge Emergency Medical Group and

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6 Id. at 88-89.
7 Id. The Knox-Keene Act is a portion of California's Health and Safety Code. See CAL. HEALTH & SAFETY CODE §§ 1340 (West 2008); infra notes 24-34 and accompanying text (detailing sections of the Knox-Keene Act).
8 See Prospect Med. Group, Inc., 198 P.3d at 89. An IPA is a "legal entity which has entered into a services arrangement (or arrangements) with persons who are licensed to practice medicine." CAL. HEALTH & SAFETY CODE § 1373(h)(6) (West 2008); 42 U.S.C. § 300e-1(5) (2006). See also Prospect Med. Group Inc., 39 Cal. Rptr. 3d at 457-48 (noting Prospect does business under the name Sierra Medical Group but tagging the group as Prospect).
9 Prospect Med. Group Inc., 39 Cal. Rptr. 3d at 459. A service plan is "[a]ny person who undertakes to arrange for provision of health care services to subscribers or enrollees, or to pay for or reimburse any part of the cost for those services, in return for a prepaid or periodic charge paid by or on behalf of the subscribers or enrollees." CAL. HEALTH & SAFETY CODE § 1345(f)(1) (West 2008). A service plan can also be:

Any person, whether located within or outside of this state, who solicits or contracts with a subscriber or enrollee in this state to pay for or reimburse any part of the cost of, or who undertakes to arrange or arranges for, the provision of health care services that are to be provided wholly or in part in a foreign country in return for a prepaid or periodic charge paid by or on behalf of the subscriber or enrollee.

10 Prospect Med. Group Inc., 39 Cal. Rptr. 3d at 459. See also CAL. HEALTH & SAFETY CODE § 1371.4(b) (West 2008) (stating service plans or their delegates must reimburse providers for emergency services given to its subscribers until point of stabilization). A provider is defined as a "professional person, organization, health facility, or other person or institution licensed by the state to deliver or furnish health care services." CAL. HEALTH & SAFETY CODE § 1345(i) (West 2008). The Superior Court noted that both parties to this action could fit within the meaning of
Saint John’s Emergency Medicine Specialist, Inc. ("Emergency Physicians") provide emergency room care services and have exclusive licenses to do so at two California hospitals. When a patient enters the emergency room and is in danger of loss of life or serious illness or injury, Emergency Physicians must provide care regardless of whether Emergency Physicians have a contract with the patient’s insurer. Prospect and Emergency Physicians do not have a contract with each other.

Balance billing occurs when a patient’s service plan or its delegate refuses to pay the full amount that a physician bills for services and the physician, in turn, bills the patient for the remaining amount. In the various factual incidents underlying this lawsuit, Prospect subscribers received emergency care from Emergency Physicians, and Emergency Physicians subsequently submitted reimbursement claims to Prospect. In some cases, Prospect paid the whole amount, but in other cases, it paid less than the amount charged. Emergency Physicians then billed the patients the balance. Prospect filed two lawsuits against Emergency Physicians seeking declaratory relief and argued that Emergency Physicians were only entitled to reasonable compensation for the

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11 Prospect Med. Group Inc., 39 Cal. Rptr. 3d at 459.
12 Id.; CAL. HEALTH & SAFETY CODE § 1317(d) (West 2008). In non-emergency situations, a patient/subscriber of a service plan or its delegate like Prospect obtains care from a provider with whom the service plan has a pre-existing contractual relationship. See Prospect Med. Group Inc., 39 Cal. Rptr. 3d at 459. In emergency situations, this is not always possible. See id. at 459-60.
13 Prospect Med. Group Inc., 39 Cal. Rptr. 3d at 458 n.1.
14 Prospect Med. Group Inc., 198 P.3d at 88. In non-emergency situations, this is not an issue because the provider and service plan or its delegate have previously contracted for the price at which the provider will be reimbursed. Id.
15 Id. at 89.
16 Prospect Med. Group Inc., 39 Cal. Rptr. 3d at 460 (dealing with specific cases occurring between September 2002 and July 2003). Prospect stated that it paid what it believed to be the reasonable amount for such services. Id.
17 Prospect Med. Group Inc., 198 P.3d at 89. It is questionable whether a physician looking to obtain a co-payment or deductible from a patient is considered to be balance billing and the parties did not specify as to such. Prospect Med. Group Inc., 39 Cal. Rptr. 3d at 460. The appeals court looked to CAL. HEALTH & SAFETY CODE § 1379(a)-(b) (West 2008). See id. Section 1379, which is part of the Knox-Keene Health Care Service Plan of 1975, states that no subscriber will be liable to providers for “any sum owed by the plan.” CAL. HEALTH & SAFETY CODE § 1379 (West 2008). The court reasoned that a physician looking to collect a deductible and/or co-payment did not fit within the definition of balance billing. See Prospect Med. Group Inc., 39 Cal. Rptr. 3d at 460. A co-payment or deductible, reasoned the court, is that which is owed by a patient and therefore does not constitute balance billing. See id.
medical services provided to its patient subscribers. Emergency Physicians demurred, and the Los Angeles County Superior Court sustained without leave to amend. Prospect filed a timely appeal to the California Court of Appeals.

The California Court of Appeals held that section 1379 of the Knox-Keene Act does not prohibit balance billing in circumstances where there is no pre-existing contract between the provider and the service plan or its delegate. The court determined that Emergency Physicians did not have a pre-existing contract with Prospect. Prospect

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18 Prospect Med. Group Inc., 39 Cal. Rptr. 3d at 460, 460 n.6 (noting Superior Court assigned both suits to one judge because they were closely related). Prospect argued that reasonable compensation would be equal to 100% of the Medicare rate and that under section 1379(b) Emergency Physicians were barred from balance billing Prospect's subscribers. See id. at 460. Prospect reasoned that, under section 1317(d), Emergency Physicians were obligated to treat its subscribers without regard to insurance or ability to pay and that Prospect was required to reimburse Emergency Physician under section 1371.4(b). See id. at 460-61. See also CAL. HEALTH & SAFETY CODE § 1371.4(b) (West 2008); CAL. HEALTH & SAFETY CODE § 1317(d) (West 2008). This situation created an implied contractual relationship that is governed by section 1379's prohibition of balance billing. See Prospect Med. Group Inc., 39 Cal. Rptr. 3d at 460-61; see also § 1379 (forbidding health care providers from billing patients/subscribers for "any sums owed by the plan"). Prospect further alleged "that the practice of balance billing constituted an unfair, unlawful, or fraudulent business practice within the meaning of [the California] Business and Professions Code section 17200." See Prospect Med. Group Inc., 39 Cal. Rptr. 3d at 460. "Prospect sought disgorgement, restitution, attorney fees and costs, as well as injunctive relief." Id.

19 See Prospect Med. Group Inc., 39 Cal. Rptr. 3d at 460.

20 Id.

21 Id. at 461. The Knox-Keene Act "provides a comprehensive system for licensing and regulating health care service plans." Id. Section 1379 states that:

(a) Every contract between a plan and a provider of health care services shall be in writing, and shall set forth that in the event the plan fails to pay for health care services as set forth in the subscriber contract, the subscriber or enrollee shall not be liable to the provider for any sums owed by the plan;

(b) In the event that the contract has not been reduced to writing as required by this chapter or that the contract fails to contain the required prohibition, the contracting provider shall not collect or attempt to collect from the subscriber or enrollee sums owed by the plan;

(c) no contracting provider, or agent, trustee or assignee thereof, may maintain any action at law against a subscriber or enrollee to collect sums owed by the plan.

§ 1379.

22 See Prospect Med. Group Inc., 39 Cal. Rptr. 3d at 461-63. Prospect argued that subsection (b) of section 1379 governed Prospect and Emergency Physicians via an implied contract. See id. at 461. The court refused to adopt this interpretation holding that section 1379 only applied to voluntarily negotiated contracts and not those implied in law. See id. The court further determined that Prospect was not "entitled to a judicial declaration imposing the Medicare rate as the reasonable rate" and that the trial court abused its discretion by denying Prospect's request.
appealed, and the California Supreme Court held that the Knox-Keene Act clearly prohibits balance billing and emergency room doctors and service plans must resolve disputes over emergency medical care solely between themselves without involving the subscriber patient.23

California’s statutory scheme concerning health care governs the issue of balance billing in non-contracting emergency situations.24 As noted in Coal. of Concerned Cmty., Inc. v. City of L.A.,25 in order to effectively interpret the legislature’s intent and the meaning of the Act, the statutory framework must be read as a whole and not in isolation.26 The Knox-Keene Act of 1975, “a comprehensive system of licensing and regulation under the jurisdiction of the Department of Managed Health Care,” applies here.27 Additionally, section 1317 compels providers in emergency situations to administer care without inquiring into a patient’s ability to pay.28 Per section 1371.4 of

for leave to amend the complaint as to the rates charged by Emergency Physicians and whether they were reasonable. See id. at 466, 468-69. The court dismissed the trial court’s denial of Prospect’s cause of action for declaratory relief and stated that on remand Prospect could amend the complaints to litigate whether Emergency Physicians charged more than a reasonable rate. See id. at 469.


24 See § 1379 (governing subscriber/patient liability); see also HEALTH & SAFETY CODE § 1371.4(b) (West 2008) (compelling service plans to reimburse providers for enrollees’ emergency care); CAL. HEALTH & SAFETY CODE § 1317(d) (West 2008) (requiring providers to administer care without first questioning payment ability); CAL. CODE REGS. tit. 28, § 1300.71(a)(3)(B) (2009) (listing factors in determining the reasonable and customary value for health care services). See generally supra notes 8-13 and accompanying text (providing applicable law and defining parties’ status using applicable law).


26 See id. (discussing court’s process in statutory interpretation). In Coal. of Concerned Cmty., the court explained that its “fundamental task in interpreting a statute is to determine the Legislature’s intent so as to effectuate the law’s purpose.” Id. The court explained that it gives the plain and commonsense meaning of the statute, but it does not look at the statute in isolation. See id. Rather, the court looks at the situation “in the context of the statutory framework as a whole in order to determine its scope and purpose and to harmonize the various parts of the enactment.” Id. If the language is clear, courts will follow the plain meaning. See id. If it has more than one reasonable interpretation, courts will look at other areas including the statute’s purpose, legislative history and public policy. See Coal. of Concerned Cmty., Inc., 101 P.3d at 565.

27 Bell v. Blue Cross of Cal., 31 Cal. Rptr. 3d 688, 691 (Cal. Ct. App. 2005). In Bell, the California Court of Appeals considered whether the law required a service plan to reimburse non-contracting providers a reasonable amount when they provided emergency care to the plan’s enrollees. Id. at 690. The court held that such an obligation existed. Id. at 697.

California's Health and Safety Code, when a subscriber to a plan receives emergency care, the plan must reimburse the physician up to the point of stabilization. The legislature enacted this section in 1994 "to impose a mandatory duty upon health care plans to reimburse non-contracting providers for emergency medical services." Section 1379 of the Knox-Keene Act explicitly prohibits balance billing when contracted service plans fail to reimburse providers for the contracted amount. It is questionable whether this prohibits balance billing in non-contracting situations. Other areas relevant to determining whether balance billing is permitted in such situations are sections 1342, 1367, 1371.37 and 1371.38 of California's Health and Safety Code. Section 1342 discusses the purpose of the Knox-Keene Act, section 1367 provides a mechanism to resolve disputes over amounts owed to contracting physicians, section 1371.37 prohibits service plans from engaging in unfair payment practices and section 1371.38 requires service plans to have an effective dispute resolution mechanism for contracting and non-contracting providers.

29 See HEALTH & SAFETY CODE § 1371.4(b) (West 2008) (rendering prior authorization from service plan unnecessary to treat if state or federal law prohibits physicians from asking about patient's ability to pay); see also Bell, 31 Cal. Rptr. 3d at 691 (describing purpose and requirements of section 1371). The statute further states that payment must be made to the provider unless the service plan, or its contracting medical providers, finds that emergency care or services were not performed or such care was not needed. See HEALTH & SAFETY CODE § 1371.4(c) (West 2008).

30 Bell, 31 Cal. Rptr. 3d at 692. See generally Cal. Emergency Physicians Med. Group v. PacifiCare of Cal., 4 Cal. Rptr. 3d 583, 589-90 (Cal. Ct. App. 2003) (determining service plans have a duty to reimburse physicians under this section). When reimbursing the provider, the service plan must pay "the reasonable and customary value for the health care services rendered based upon statistically credible information that is updated at least annually." CAL. CODE REGS. tit. 28, § 1300.71(a)(3)(B) (2009). Such factors include provider training, nature of the services provided, prevailing provider rates in that area and unusual circumstances. Id.

31 See CAL. HEALTH & SAFETY CODE § 1379 (West 2008). More specifically, this section requires contracts between service plans and providers to be set forth in writing and clearly state that in the event the service plan fails to pay the contracted amount, the subscriber or enrollee will not be held liable nor shall the provider have a legal claim against the enrollee or subscriber. See CAL. HEALTH & SAFETY CODE § 1379(a), (c) (West 2008). Even if it is not in writing, this rule governs. See CAL. HEALTH & SAFETY CODE § 1379(b) (West 2008).

32 See § 1379 (failing to explicitly provide for whether prohibition on balance billing applies where no express contract exists).

33 See infra note 34 and accompanying text.

34 Under section 1342(d), the purpose of the Knox-Keene Act, among other things is to: promote the delivery and the quality of health and medical care to the people of the State of California who enroll in, or subscribe for the services rendered by, a health care service plan or specialized health care service plan by . . . [h]elping to ensure the best possible health care for the public at the lowest possible cost by transferring the financial risk of health care from patients to
The legislative policy behind the Knox-Keene Act is also relevant in determining the legislature's intentions regarding the Act and, specifically, balance billing. In *Bell v. Blue Cross of Cal.*, the California Court of Appeals recognized the "legislative policy" of keeping patients out of disputes between providers and service plans and supported the policy to avoid balance billing. However, both potential statutes and regulations as well as case law suggest that balance billing is allowed in certain situations including where non-contracting providers render services in an

providers.

CAL. HEALTH & SAFETY CODE § 1342 (West 2008). Under section 1367, the legislature set forth a mechanism to resolve disputes over amounts owed to contracting providers. See CAL. HEALTH & SAFETY CODE § 1367(h)(1) (West 2008). Section 1371.37 prohibits service plans from engaging in unfair payment patterns. See CAL. HEALTH & SAFETY CODE § 1371.37 (West 2008). Finally, under section 1371.38, the legislature required the director of Department of Managed Health Care to adopt regulations necessitating that each service plan has a fair, fast and cost effective dispute resolution mechanism for contracting and non-contracting providers. See CAL. HEALTH & SAFETY CODE § 1371.38(a) (West 2008).

See Torres v. Parkhouse Tire Serv., Inc., 30 P.3d 57, 61 (Cal. 2001) (noting procedure when more than one reasonable interpretation of statute is possible); see also Coal. of Concerned Cmtys., Inc. v. City of L.A., 101 P.3d 563, 565 (Cal. 2004) (recognizing courts look to legislative policy when more than one reasonable interpretation exists such as the statute's purpose, legislative history and public policy). In situations where there is more than one reasonable interpretation, courts can look to outside sources like the purpose of the statute, evils to be remedied, legislative history, public policy and the statutory scheme. See Torres, 30 P.3d at 61. Ultimately, the interpretation should be one that most closely parallels the apparent intent of the legislature and the statutory purpose, avoiding interpretations leading to absurd consequences. See id. Courts throughout the country follow this method of statutory construction. See, e.g., King v. St. Vincent's Hosp., 502 U.S. 215, 221 (1991) (affirming statutes must be read as a whole); Richards v. U.S., 369 U.S. 1, 11 (1962) (looking to the statute as a whole as well as its object and policy); McKenna v. First Horizon Home Loan Corp., 475 F.3d 418, 423 (1st Cir. 2007) (utilizing traditional forms of statutory construction such as looking to language, structure, purpose and history of the statute); Sutka v. Conners, 538 N.E.2d 1012, 1015 (N.Y. 1989) (emphasizing legislative intent gleaned from face of statute and "spirit and purpose" of legislation).

See Bell v. Blue Cross of Cal., 31 Cal. Rptr. 3d 688, 693 (Cal. Ct. App. 2005) (interpreting legislative policy). In *Bell*, the court stated:

[i]f providers are precluded from bringing private causes of action to challenge health plans' reimbursement determinations, health plans may receive an unjust windfall and patients may suffer an economic hardship when providers resort to balance billing activities to collect the difference between the health plan's payment and the provider's billed charged. If collection actions are pursued, unsuspecting enrollees can be forced to reimburse the full amount of a provider's billed charges even though those charges are in excess of the reasonable and customary value of the services rendered.

Id.
emergency situation. Nevertheless, while this case was pending, the Department of Managed Health Care ("DMHC") adopted a regulation that considers balance billing in emergency situations an unfair billing practice. It is unclear whether a court should or must give deference to a regulation promulgated after the events that gave rise to the case occurred.

In Prospect, the court considered whether providers, who administered emergency care to patient enrollees of non-contracting service plans, could engage in balance billing. The court looked to the Knox-Keene Act and its relevant sections to determine California's approach to patient care in emergency situations and the potential for balance billing that results. The court clearly ascertained that California requires providers to administer emergency care to patients regardless of their ability to pay. Health plans must then reimburse providers regardless of whether a contract existed between the service plan and the provider. The court next looked to section 1379 to determine whether the legislature prohibited balance billing and weighed both Prospect's and the lower court's arguments. The court noted that section 1379 did not expressly

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41 See id. at 90 (discussing relevant sections of Knox-Keene Act as well as section 1317). See also supra notes 24-34 and accompanying text (explaining Knox-Keene Act and relevant sections).
42 See Prospect Med. Group, Inc., 198 P.3d at 90 (relying on section 1371.4 and reasoning in Bell to make such determination).
43 See id. The court also noted that service plans do not have to reimburse providers if emergency services were never performed. See id. See also HEALTH & SAFETY CODE § 1371.4(c) (West 2008).
44 See Prospect Med. Group, Inc., 198 P.3d at 91-94 (taking up Prospect and lower court's arguments). See generally supra note 21 (articulating standards provided in section 1379). Prospect argued that while they did not have a written contract with Emergency Physicians, as set out in section 1379(a), the two parties had an implied contract that had not been reduced to writing as
ban balance billing in the current situation. However, the court stated that it could reasonably interpret that the Knox-Keene Act banned this billing practice when considering the legislature's overall statutory framework.

To further support its decision, the court turned to legislative policy. Relying on Bell, the court recognized a clear legislative policy against balance billing. The court set out in section 1379(b). See Prospect Med. Group, Inc., 198 P.3d at 91. The Court of Appeals did not agree and interpreted section 1379 as a whole determining that section 1379(b) only dealt with voluntarily negotiated contracts between providers and service plans where a traditional meeting of the minds occurred. See id. Thus the current situation did not meet the requirements of section 1379(b). See id.

The court explained that in interpreting the meaning of the Act the court must “not examine [statutory] language in isolation, but in the context of the statutory framework as a whole in order to determine its scope and purpose and to harmonize the various parts of the enactment.” See id. at 91 (quoting Coal. of Concerned Cmtys., Inc. v. City of L.A., 101 P.3d 563, 565 (Cal. 2004)). The court then went through the statutory scheme noting that section 1379 banned balance billing where the service plan and providers had an existing contract. See id. at 91-92. Further, providers can sue service plans over billing disputes, which suggests the legislature did not want to involve patients in billing disputes. See id. The court also noted that while section 1317(d) requires providers to administer emergency care to patients without questioning patient's payment abilities, following care patients must pay providers or supply insurance information. See id. The court reasoned that this suggests that once insurance information is given, patients have satisfied their obligations to doctors. See Prospect Med. Group, Inc., 198 P.3d at 91-92. Furthermore, section 1342 expresses a legislative intent to provide the lowest possible health care costs and section 1367 and section 1371.38 set out dispute resolution mechanisms for non-contracting providers. See id. at 92. Finally, the court noted that under section 1371.39 the legislature looked to protect non-contracting providers in reimbursement disputes by “prohibiting HMO's from engaging in unfair payment patterns involving unjust payment reductions, claim denials, and other unfair practices . . . .” Id.

Relying on Torres for the proposition of looking to extrinsic aids when more than one reasonable interpretation is possible. See also supra note 35 (discussing courts' methods of statutory interpretation). See generally Lisa Girion, Hospitals Protest New California Rules on Billing: Physicians also dispute a ban on charging emergency room patients for balances not paid by insurers, L.A. TIMES, October 15, 2008, at C-1 (providing further policy support for prohibition of balance billing). A prohibition on balance billing takes the patient out of the middle of a provider and service plan dispute. See Girion, supra at C-1. This protects the patient from the potentially inflated health care costs, double payment (paying both their insurer and provider) and credit problems. See id. See also Angela M. Lai & Dylan McClelland, California Ends Balance Billing, 5 A.B.A. HEALTH ESOURCE (2000), http://www.abanet.org/health/esource/Volume5/06/Lai.html (explaining harsh credit tactics that occur when patients cannot pay remaining amount or their balance bill).

In Bell, the court determined that doctors may directly sue HMOs in billing disputes to avoid balance billing. See Bell, 31 Cal. Rptr. 3d at 692. The court reasoned that not only did this support a legislative policy against balance billing, but it also did away with the necessity of allowing balance billing because doctors could sue service
then addressed and subsequently rejected the arguments of Emergency Physicians.\textsuperscript{49} The court determined that the statutory framework and legislative policy supported the view that balance billing is prohibited in non-contracting emergency situations.\textsuperscript{50}

In *Prospect*, the California Supreme Court correctly interpreted the overall statutory framework of the Knox-Keene Act.\textsuperscript{51} It looked at relevant portions of the Knox-Keene Act and found ample support for a prohibition against balance billing in a non-contractual setting.\textsuperscript{52} To further affirm its actions, the court rightly looked to

plans in court. See *Prospect Med. Group, Inc.*, 198 P.3d at 93.

\textsuperscript{49} See id. at 93-94 (rejecting arguments of claims for reimbursements and pertinence of vetoed legislation). Emergency Physicians argued and the court rejected the notion that under *Ochs*, providers may bill patients who can, then, seek reimbursement from their service plans and that section 1379 only limited balance billing in contract situations. See id. at 93. See also Harry W.R. Chamberlain II, *Out of Balance: The California Supreme Court Will Decide Whether “Balance Billing” Unfairly Puts Patients in the Middle of Fee Disputes between Providers and Health Plans*, 49 DEC. ORANGE COUNTY LAW. 26, 33 (2007) (explaining providers must establish a private review process to resolve disputes or file suit). Further, the court rejected Emergency Physicians’ arguments that vetoed legislation could be considered in the court’s reasoning. See *Prospect Med. Group, Inc.*, 198 P.3d at 93-94. It also discarded the notion that section 1300.63.1, which requires health plans to inform enrollees in writing that they may be liable for bills that the plan does not pay, authorizes balance billing. See id. at 94. The court reasoned that this regulation, which came long before statutes concerning administration of emergency care, deals with situations where enrollees go outside their network in non-emergency situations. See id. Finally, the court briefly acknowledged Emergency Physicians’ conclusion that because emergency room doctors receive inadequate compensation and emergency rooms are already at capacity, such a decision will only further jeopardize quality of care. See id. at 90-94. Specifically, in their amicus curiae brief, Emergency Physicians argued that service plans are inadequately compensating emergency room physicians and subjecting them to unfair contracts while retaining the majority of patient premiums. See Application for Leave to File and Amicus Curiae Brief of the Cal. Med. Ass’n. in Support of Defendants and Respondents at 4-20, *Prospect Med. Group, Inc. v. Northridge Emergency Med. Group*, 198 P.3d 86 (Cal. 2009) (No. S142209). Such practices result in physicians dropping out of networks and patients, in turn, experiencing difficulties in accessing emergency room care. See id. at 4-12. In their view, further regulation of physicians’ abilities to balance bill will only increase these problems. See id. at 12. The court, however, noted that this larger problem of inadequate care was not at issue in this case. See *Prospect Med. Group, Inc.*, 198 P.3d at 94; see also Application for Leave to File and Amicus Curiae Brief by the Cal. Dep’t of Managed Health Care in Support of the Plaintiffs and Appellants at 29-31, *Prospect Med. Group, Inc. v. Northridge Emergency Med. Group*, 198 P.3d 86 (Cal. 2009) (No. S142209) (refuting the “Chicken Little – the sky is falling” theory as extreme and unrealistic).

\textsuperscript{50} See *Prospect Med. Group Inc.*, 198 P.3d at 94 (refusing to deal with recently passed legislation against balance billing as non-contemporaneous).

\textsuperscript{51} See id. at 92 (interpreting statutory framework to prohibit balance billing).

\textsuperscript{52} See supra note 46 and accompanying text (referencing various provisions of Knox-Keene Act as well as section 1317(d) that clearly support prohibition on balance billing).
legislative policy and intent, which also justified such a ban.53 Courts throughout the country continue to look to the overall statutory framework, legislative policy and intent when attempting to interpret laws.54 This continued practice justifies the court’s method of analysis.55

Some might argue, however, that the court went too far in its interpretation of the Knox-Keene Act.56 The court explicitly admitted that section 1379 did not expressly ban balance billing practices in situations of non-contracting providers.57 Even after admitting this fact, the court refused to acknowledge its relevance and instead looked for justification in other areas of the law.58 Thus the court ignored the portion of the statute most relevant to the situation at hand to obtain the answer it desired.59 It is also debatable whether section 1379 was the only relevant portion of the statute.60 Basic rules of statutory construction and interpretation require looking to the statutory framework as a whole, especially where ambiguity exists.61 Ultimately, the legislature made it clear through the DMHC that balance billing is an unfair billing practice that is not acceptable in contracting or non-contracting situations.62 This affirmation substantiates the court’s decision.63

This case will benefit patients by eliminating balance billing and expanding access to care without harming providers.64 Providers argue that such a decision, which

53 See supra notes 47-48 and accompanying text (focusing on legislative intent and finding ample backing for striking down balance billing attempts).
54 See supra note 35 (exploring court’s role in analyzing meaning of statutes).
55 See supra note 35.
57 See Prospect Med. Group, Inc., 198 P.3d at 91 (acknowledging section 1379 does not cover non-contracting balance billing dilemmas).
58 See id. at 91-92 (ignoring section 1379 and looking elsewhere to find desirable result).
59 See id.
60 See supra notes 34-37 (referencing statues, cases and policy that suggest looking beyond section 1379).
61 See supra note 35 (referencing cases that discuss process for interpreting statutes).
63 See id.
64 See Girion, supra note 47, at C-1 (pointing to benefits of ban on balance billing); see also Lai, supra note 47 (discussing negative, costly effects of balance billing that will be eliminated because of the court’s decision).
attempts to expand access to care, will ironically decrease it.\footnote{See Application for Leave to File and Amicus Curiae Brief of the Cal. Med. Ass'n. in Support of Defendants and Respondents at 4-20, Prospect Med. Group, Inc. v. Northridge Emergency Med. Group, 198 P.3d 86 (Cal. 2009) (No. S142209).} They argue that California is currently on a slippery slope in which service plans are paying providers less, causing providers to leave the market and in turn subjecting patients to delays in treatment and insufficient medical care.\footnote{See id.} Providers argue this decision will only take California further along this path.\footnote{See id.} This argument, however, fails to take into account the true nature of the problem and incorrectly punishes unsuspecting patients.\footnote{See Prospect Med. Group, Inc. v. Northridge Emergency Med. Group, Inc., 198 P.3d 86, 94 (Cal. 2009) (recognizing Emergency Physicians’ arguments discuss a larger problem not at issue in this case); \textit{see also supra} note 36 and accompanying text (recognizing the importance of keeping patients out of the dispute); CAL CODE REGS. tit. 28, § 1300.71.39 (2009) (prohibiting balance billing in emergency situations).} In reality, the above contentions are grounded in the belief that service plans are not adequately paying providers.\footnote{See id.} If this is the case, the remedy lies not with balancing bill patients, but with changing and regulating service plans’ practices.\footnote{See Application for Leave to File and Amicus Curiae Brief of the Cal. Med. Ass’n. in Support of Defendants and Respondents at 5-7, 15-16, Prospect Med. Group, Inc. v. Northridge Emergency Med. Group, 198 P.3d 86 (Cal. 2009) (No. S142209).} It is not the responsibility of the patient to account for service plans’ insufficient payments.\footnote{See id.} The patient has already paid for his insurance and should not be subject to an additional, potentially inflated, costly provider bill.\footnote{See Application for Leave to File and Amicus Curiae Brief of the Cal. Med. Ass’n. in Support of Defendants and Respondents at 30-31, Prospect Med. Group, Inc. v. Northridge Emergency Med. Group, 198 P.3d 86 (Cal. 2009) (No. S142209).} Rather, this decision, along with the corresponding DMHC
regulation, will eliminate the unfair results of balance billing and provide much needed patient protection and access to care.73

In *Prospect*, the California Supreme Court addressed whether non-contracting providers could balance bill patients for emergency care services.74 The court correctly determined that balance billing was prohibited in such situations.75 This decision not only parallels the intentions of California’s state legislature and DMHC, but also provides patients with ample protection against inappropriate, cost inflated medical bills.76

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73 See Girion, *supra* note 47, at C-1 (pointing to benefits of ban on balance billing).
74 *Prospect Med. Group, Inc.*, 198 P.3d at 88-89.
75 *Id.*
76 *See Cal Code Regs.* tit. 28, § 1300.71.39 (2009); *supra* note 72.